KAMALA D. HARRIS
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
KAREN R. DENVIR
Deputy Attorney General
State Bar No. 197268
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5333
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **WENDY O. SHARP, AKA** **WENDY O. ABLES** 223 Hackberry Avenue Modesto, California 95354 **Registered Nurse License No. 397453** Respondent.	Case No. 2013-915 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about March 31, 1986, the Board issued Registered Nurse License Number 397453 to Wendy O. Sharp, also known as Wendy O. Ables ("Respondent"). The Registered Nurse License will expire on May 31, 2013.

///

///

///

JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

5. Code section 118, subdivision (b), provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

STATUTORY PROVISIONS

6. Code section 2761 provides, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

BACKGROUND INFORMATION

10. In or around June 2010, Respondent was employed by Nightingale Nurse Services and was working as a registered nurse at Lloyd's Liberty Homes, Inc. (LLH), an immediate care facility in Modesto, California. On or about June 19, 2010, Respondent was the on-call registered nurse for LLH.

11. Patient A was an elderly resident at LLH. His medical history included a seizure disorder, stroke, left-sided weakness, lung cancer, and chronic obstructive pulmonary disease.

12. On or about June 12, 2010, Patient A's physician ordered Coumadin 2 mg., three times a week, for Patient A., which Respondent recorded in her Nursing Progress Notes. Coumadin is a brand name for warfarin, an anticoagulant (blood thinner). On or about June 17, 2010, Respondent received an order from Patient A's physician to change Patient A's Coumadin dose to 4.0 mg., four times a week, a significant increase. Respondent recorded the order in her Nursing Progress Notes.

13. Respondent charted in her Nursing Progress Notes that on June 19, 2010, at 06:30, she received a call from LHH staff, who reported that Patient A, didn't look good, had a mostly sleepless and restless night, was afraid of falling, would yell out often, was confused, coughed up a small amount of blood, voided dark tea-colored urine, and that staff had earlier called a licensed vocational nurse at 03:00. Respondent requested LHH staff to take Patient A's vital signs and call her back. Respondent later stated that although she charted Patient A's symptoms as reported by LHH staff on June 19, 2010, at 06:30, she was not made aware of all of those symptoms at that time.

14. LHH staff contacted Respondent a short while later and told her that Patient A told them he didn't feel right. Respondent told them to observe him, increase fluids, and contact her with changed signs or symptoms. Respondent then tried to contact Patient A's physician. LHH staff contacted Respondent again at approximately 07:30, informing Respondent that Patient A appeared to have blood on his hands and shirt, and it looked like he had voided blood in his urine. Respondent instructed them to call her back with any other changes. At approximately 09:40, Respondent was informed that Patient A's physician was not available, that a physician would not be available until 12:00, and that she should call the emergency room at Merced Hospital if there was an emergency. LHH staff subsequently reported to Respondent that Patient A appeared to have dried blood in his mouth and at the back of his throat.

15. At approximately 12:45, more than six hours after the first call Respondent received regarding Patient A's condition, Respondent arrived at LLH to assess him. She found he was cyanotic, his breathing shallow, and his urine dark and tea-colored. Respondent contacted Patient A's physician's assistant. The physician's assistant ordered the transfer of Patient A to a hospital emergency room. Respondent called 911. Respondent went to the emergency room at Merced Medical Center in Merced, California ("Emergency Room") where Patient A was taken. When asked by Emergency Room personnel what Patient A's code status was, she was unable to tell them and she was unable to find it in records for Patient A, which were brought from LHH.

16. On June 19, 2010, the emergency room physician's diagnosis for Patient A included sepsis, pneumonia, and Coumadin toxicity.

17. Respondent later admitted that she should have personally assessed and transferred Patient A to an emergency room earlier.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or around June 2010, while working as a registered nurse at Lloyd's Liberty Homes, Inc. in Modesto, California, Respondent committed

acts constituting gross negligence within the meaning of the California Code of Regulations, title 16, section 1442, as follows and as more fully set forth in paragraphs 10 through 17, above:

a. On or about June 19, 2010, as regards Patient A:

i. Respondent failed to properly assess Patient A's condition by failing to ascertain his code status, his medications, or his laboratory values.

ii. Respondent failed to timely assess Patient A's condition.

iii. Respondent failed to report to a hospital emergency room when she was unable to reach a physician.

iv. Respondent failed to timely call "911".

v. Respondent inaccurately charted events in her nursing notes.

b. Between on or about June 17, 2010, and June 19, 2010, Respondent failed to question the significant increase in Patient A's Coumadin prescription.

c. In or around June 2010, including on or about June 19, 2010, Respondent failed to follow policies of Lloyd's Liberty Homes, Inc. regarding physician notification, patient emergency, and facility transfer protocol.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that, in or around June 2010, while working as a registered nurse at Lloyd's Liberty Homes, Inc. in Modesto, California, Respondent committed acts constituting incompetence within the meaning of the California Code of Regulations, title 16, section 1443, as set forth in paragraph 18, above, and by failing to be sufficiently knowledgeable as to her scope of authority and her role in relation to patient safety.

///

///

///

///

///

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that that in or around June 2010, while working as a registered nurse at Lloyd's Liberty Homes, Inc. in Modesto, California, Respondent demonstrated unprofessional conduct, as set forth in paragraphs 18 and 19, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 397453, issued to Wendy O. Sharp, also known as Wendy O. Ables;

2. Ordering Wendy O. Sharp, also known as Wendy O. Ables, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: APRIL 17, 2013

for LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
State of California
Complainant

SA2012108172
11008001.doc